STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF EXAMINATION

OF

ALTIUS HEALTH PLANS INC.

AS OF

DECEMBER 31, 2001

TABLE OF CONTENTS

September 20, 2002

Honorable Merwin U. Stewart, Commissioner
State of Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114-6901

In accordance with your instructions and in compliance with Utah Code Annotated (U.C.A.) Title 31A, an examination of the financial condition and business affairs of

ALTIUS HEALTH PLANS INC.

a health maintenance organization ("HMO"), hereinafter referred to as the Organization, was conducted as of December 31, 2001.

SCOPE OF EXAMINATION

Period Covered by Examination

The Utah Insurance Department's ("Department") last financial examination of the Organization was conducted as of March 31, 1998. The current examination covers the period from April 1, 1998, through December 31, 2001, including any material transactions and/or events occurring subsequent to the examination date noted during the course of the examination.

Examination Procedure Employed

The examination included a general review and analysis of the Organization's operations and a determination of its financial condition as of December 31, 2001. Material assets were valued and ownership verified. Liabilities were determined in accordance with laws, rules, and procedures prescribed by the State of Utah. The examination was conducted in accordance with generally accepted standards and procedures of regulatory authorities relating to such examinations. It included tests of the accounting records and a review of the Organization's affairs and practices to the extent deemed necessary.

The Organization retained the services of a certified public accounting firm to audit its financial records for the period under examination. The firm provided requested working papers prepared in connection with its audits. The use of the firm's working papers did not significantly affect the nature and extent of examination procedures performed. The examiners relied upon the CPA firm's correspondence regarding pending or threatened litigation, claims, and assessments received from the Organization's legal representatives.

The examiners relied on the findings of an actuarial firm contracted by the Department to verify unpaid claims and unpaid claims adjustment expenses. Examiners were responsible for

testing the completeness of the records provided to the actuarial firm and the accuracy of the underlying data used to establish the liability amounts.

A letter of representation certifying that management has disclosed all significant matters and records was obtained from management and has been included in the examination working papers.

Status of Adverse Findings, Material Changes in the Financial Statement, and Other Significant Regulatory Information Disclosed in the Previous Examination

Effective September 30, 1998, a change of control and a complete restructuring of the Organization occurred. As a result, many of the prior examination findings were not relevant to the current examination. Relevant items of significance or special interest noted in the prior examination report have been addressed by the Organization or have received further comment in this report.

HISTORY

General

The Organization was organized and incorporated under the laws of Utah on July 1, 1987, as FHP of Utah, Inc., a wholly owned subsidiary of FHP, Inc. The Organization was certified as an HMO on July 27, 1987, and became federally qualified on October 24, 1995. In March 1997 PacifiCare Health Systems, Inc. ("PHSI") acquired control of FHP, Inc. and its subsidiaries. Following the acquisition, PHSI became the ultimate controlling person in the holding company system and the Organization's name was changed to PacifiCare of Utah, Inc.

Effective September 30, 1998, Elan Health Partners LLC ("Elan"), a Utah limited liability company, acquired all of the issued and outstanding stock of the Organization. On September 20, 2001, Croghan & Sipf Healthcare Enterprises, LLC ("Croghan & Sipf"), a Delaware limited liability company, purchased 50,000 shares of common stock and 2,400,000 shares of preferred stock from the Organization.

Articles of Amendment and Restatement of Articles of Incorporation, which changed the name of the Organization from PacifiCare of Utah, Inc. to Altius Health Plans Inc. were approved by the Department on October 1, 1998. New Bylaws with an effective date of October 5, 1998, were subsequently adopted. Amended and Restated Bylaws were adopted on April 24, 1999. On September 10, 2001, revised Articles of Amendment and Restatement of Articles of Incorporation were approved by the Department.

Capital Stock

The Articles of Amendment and Restatement of Articles of Incorporation authorized the Organization to issue 130,000 shares of no par value common stock and 3,400,000 shares of $1.00 par value preferred stock. U.C.A. § 31A-5-305(1)(a)(iii), which is made applicable by U.C.A. § 31A-8-214, requires common stock to have a stated par value. The Organization was

not in compliance with this requirement. The Organization assigned a $2.00 value to each share of common stock. As of December 31, 2001, 3,400,000 shares of preferred stock were issued and outstanding. Authorized common stock shares were allocated as follows:

Description	Shares
Issued and outstanding	109,000
Stock options	11,762
Stock warrants	9,000
Unallocated	238
Total	130,000

Croghan & Sipf and Elan each owned 50,000 shares of common stock and were the immediate controlling persons. Each entity was more than 10 percent owned by other persons. (Refer to **AFFILIATED COMPANIES**)

Dividends to Stockholders

No dividends were declared or paid during the examination period.

Management

U.C.A. § 16-10a-728, which is made applicable by U.C.A. § 31A-8-215, and U.C.A. § 31A-5-408, and the Organization's bylaws require that directors be elected by a plurality of the votes cast by shares entitled to vote. The bylaws state that directors may not be elected by written consent, except by unanimous written consent of all shares entitled to vote. Throughout the examination period, directors were elected by unanimous written consent.

Pursuant to a Shareholders Agreement, effective September 20, 2001, the size of the Organization's board was set at nine. Under conditions stated in the Shareholders Agreement, shareholders agreed to elect individuals designated by significant shareholders to the board of directors. Croghan & Sipf, was given the right to designate five board members, Elan was given the right to designate two board members, and SunAmerica, Inc. was given the right to designate two board members.

U.C.A. § 31A-5-407(2), which is made applicable by U.C.A. § 31A-8-215, requires that a majority of the Organization's directors be Utah residents unless the Commissioner is satisfied that the Organization's financial condition, management, and other circumstances give assurance that the interests of insureds and the public will not be endangered by the majority being nonresidents. In a letter, dated October 19, 2001, the Commissioner expressed such satisfaction and permitted the individuals identified on the following page to serve as board members.

The following directors were serving the Organization on December 31, 2001:

Name – Location	Designating Shareholder	Principal Affiliation
Eric D. Sipf, Chairman Englewood, Colorado	Croghan & Sipf	President E Pro Health
Raymond D. Croghan Longmont, Colorado	Croghan & Sipf	President Croghan & Associates
James J. Riggs Englewood, Colorado	Croghan & Sipf	President Essex Financial Group
John G. Lewis Denver, Colorado	Croghan & Sipf	Attorney Ireland, Stapleton, Pryor & Pascoe P.C.
Eric J. Kramer Boulder, Colorado	Croghan & Sipf	Partner Crestone Capital Advisors LLC
Val H. Christensen Orem, Utah	Elan	Vice Chairman Altius Health Plans Inc.
Kurt B. Larsen Park City, Utah	Elan	Partner Black Diamond Capital Partners LLC
Craig L. McKnight Tulsa, Oklahoma	SunAmerica, Inc.	Chief Financial Officer Hillcrest Healthcare System
Scott H. Richland Los Angeles, California	SunAmerica, Inc.	Senior Vice President SunAmerica, Inc.

The Organization's bylaws provide for principal officers to consist of a chief executive officer, president, and a secretary. The Organization may also have other officers and assistant officers as determined by the board of directors. Officers serving the Organization on December 31, 2001, were:

Officer	Office
Larry D. Hancock	Chief Executive Officer
Michael D. Bahr	President
Monte R. Deere	Secretary
Lance R. Davis	Chief Financial Officer
Dennis T. Harston	Chief Medical Officer
Val H. Christensen	Vice Chairman of the Board

Employment Agreements were entered into with Larry D. Hancock, Val H. Christensen, Dennis T. Harston, and Lance R. Davis, effective October 1, 1998. The agreement with Val H. Christensen was terminated and replaced with a consulting agreement on September 20, 2001. An employment agreement was entered with Michael D. Bahr effective July 17, 2000. Under the employment agreements, the Organization agreed to employ each individual for an indefinite term. The term may be terminated for other than cause by giving the employee a full one-year's advance notice or payment of severance pay in lieu of notice.

Stock options were granted to Larry D. Hancock, 2,843 shares, Val H. Christensen, 1,925 shares, Michael D. Bahr, 3,893 shares, and Lance R. Davis, 3,101 shares, on October 25, 2001. Mr. Christensen's option vests one hundred percent three years after the date of the grant. The other options vest as follows: 65% after two years, 90% after four years, and 100% after five years. The options expire on October 25, 2011.

U.C.A. § 31A-8-215 applies U.C.A. § 31A-5-412 to HMOs, which permits the board of directors, by resolution adopted by a majority of the full board, to designate one or more committees. Although the board did not adopt a resolution designating committees, the board approved the following directors that constituted the membership of the Organization's committees at the examination date:

Audit Committee	Compensation Committee
Val H. Christensen, Chairman	Raymond D. Croghan, Chairman
James J. Riggs	Scott H. Richland
Eric J. Kramer	Craig L. McKnight
Kurt B. Larsen	John G. Lewis

Effective June 15, 2001, the Organization entered into a seven-year Services Agreement with The TriZetto Group, Inc. ("TriZetto"). Under the agreement, TriZetto agreed to provide administrative, management, and technology services and grant certain license rights to the Organization. TriZetto became responsible for implementing the general day-to-day management and administration of the Organization's business. Sixty-seven of the Organization's employees were ultimately transferred to TriZetto. The transferred employees were employed in the claims, facility administration, information services, and system operations departments. The Organization agreed to pay a monthly service fee per enrollee as specified in the agreement. In addition, the Organization agreed that if it terminated the service agreement at any time within the seven-year term, a proportional amount of the proceeds from a $6,000,000 asset sale would be refunded to TriZetto.

Effective July 5, 2002, the TriZetto Services Agreement was amended and restated. Under the amended and restated agreement, the monthly service fee per enrollee was reduced and the refund of a proportional amount of the proceeds from the asset sale, $5,120,000, was required to be paid to TriZetto. Beginning July 1, 2005, or on any earlier date following a change of control, the Organization has the right to terminate the agreement upon payment of a termination fee equal to $1,000,000 on or prior to the effective date of the termination. Immediately upon the consummation of a change in control, the Organization must pay TriZetto a transaction fee based on the net proceeds of the transaction. The transaction fee may not exceed $2,000,000.

adequately approve and support the Organization's transactions and events. Material exceptions noted:

- Board committees were not designated by board resolution.
- One officer was not appointed.
- Policy forms were not approved.
- Underwriting guidelines were not reviewed or approved.
- Provider contract forms were not approved.
- Investment transactions were not ratified.
- Securities custodial agreements were not authorized by board resolution.
- Reinsurance transactions were not approved.
- A copy of the prior Department examination report was not furnished to each member of the board, as required by U.C.A. § 31A-2-204(8).

Acquisitions, Mergers, Disposals, Dissolutions, and Purchases or Sales through Reinsurance

In 1999 the Organization formed a wholly owned subsidiary, Altius Health Administrators Inc. Effective December 16, 1999, the Department licensed Altius Health Plan Administrators Inc. as a Third Party Administrator.

On October 31, 1999, the Organization acquired certain assets and liabilities of Intergroup of Utah, a subsidiary of Foundation Health Plans. The acquisition was accounted for as a purchase.

Surplus Debentures

Effective September 30, 1998, surplus notes in the amount of $700,000 and $500,000 were issued respectively to PHSI and Elan. In 1999, with approval of the Commissioner, the Organization redeemed the PHSI surplus note by paying all principal and outstanding interest.

Effective June 30, 1999, SunAmerica Inc. was issued a surplus note in the amount of $8,000,000. Effective August 6, 1999, surplus notes were issued to Black Diamond Capital Partners LLC and Hunter Capital Group, LLC. Principal amounts were $196,000 and $84,000, respectively. All of the surplus notes were restructured on September 20, 2001. As part of the restructuring, accrued interest was converted into principal. The restructuring created a discount on surplus notes of $1,018,000. The discount resulted from the issuance of 1,000,000 shares of one-dollar par value preferred stock for an extension of the maturity date of the SunAmerica note and the issuance of 9,000 shares of common stock warrants to note holders. The common stock had a stated value of two dollars per share.

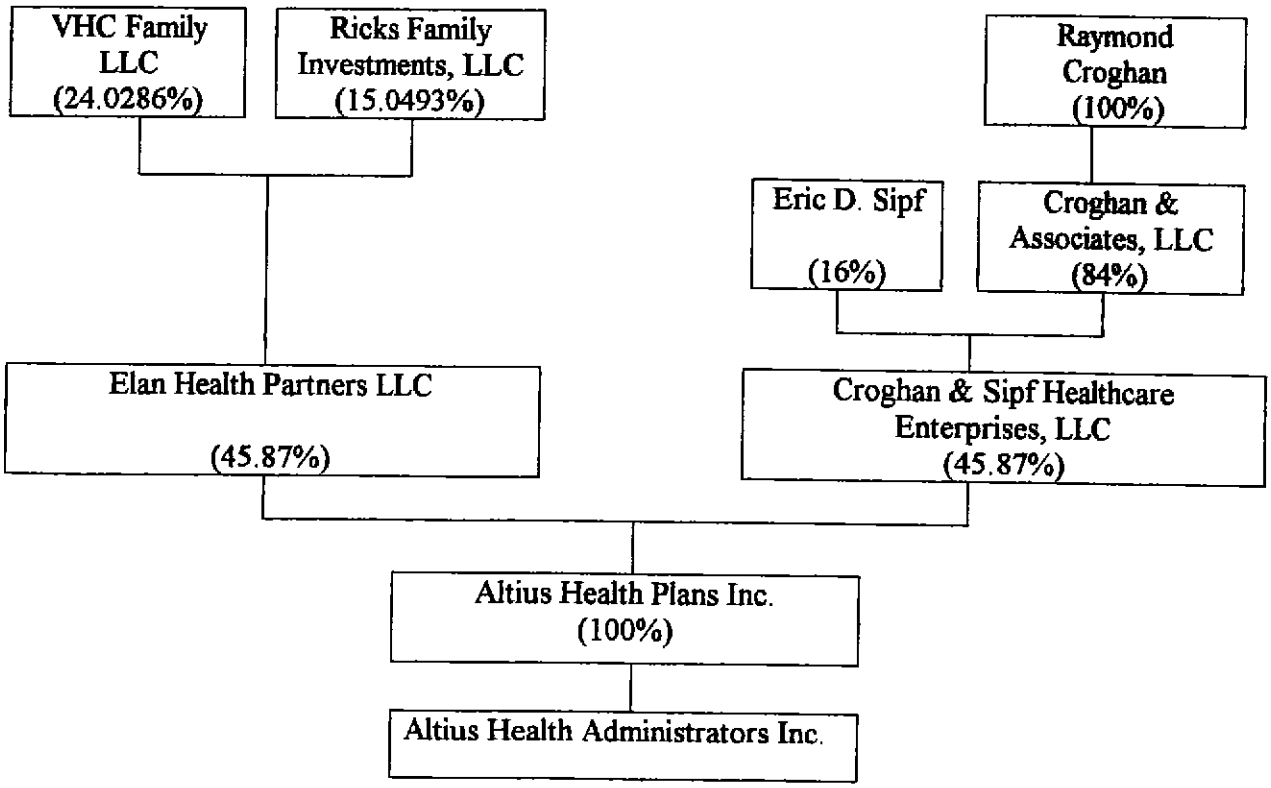
The following surplus notes were outstanding as of December 31, 2001.

Note Holder	Principal Amount
Sun America Inc.	$11,159,825
Elan Health Partners LLC	648,630
Black Diamond Capital Partners LLC	256,393
Hunter Capital Group, LLC	109,883
Gross Surplus Notes	$12,174,731
Discount on Notes	(1,018,000)
Net Surplus Notes	$11,156,731

AFFILIATED COMPANIES

The Organization is a member of an insurance holding company system. An organizational chart presenting the identities of and interrelationships between the Organization and its affiliates on December 31, 2001, follows:

Insurance Holding Company System



Although Elan Health Partners LLC and Croghan & Sipf Healthcare Enterprises, LLC each own 50,000 shares of common stock of the Organization, Croghan & Sipf Healthcare

Enterprises, LLC has a contractual right to designate five out of nine members of the Organization's board of directors.

Altius Health Administrators Inc. ("AHA") was incorporated in 1999 for the purpose of providing health insurance administrative services to third parties. Effective December 16, 1999, AHA was licensed as a Third Party Administrator by the Department. In conjunction with the license, AHA entered into a management agreement with the Organization to provide administrative, consulting, and other services necessary to conduct AHA's operations. The Organization did not notify the Commissioner in writing of its intention to enter into the transaction at least 30 days prior to entering into the transaction as required by U.C.A. § 31A-16-106(1)(b)(iv).

FIDELITY BOND AND OTHER INSURANCE

The amount of fidelity insurance coverage recommended by the National Association of Insurance Commissioners for an insurer of the Organization's size was between $800,000 and $900,000. The Organization had fidelity coverage with a single loss limit of $500,000. The coverage did not extend to Organization employees that were transferred to TriZetto under a service agreement. (Refer to **HISTORY** – Management) The Organization was also a named insured under policies providing coverage for:

- business personal property including computers;
- general liability;
- employee benefits program administration liability;
- automobile;
- umbrella or excess liability;
- managed care organization errors and omissions liability;
- employment practices liability;
- employee benefit plan fiduciary liability;
- workers' compensation; and
- directors, officers and private company liability.

PENSION, STOCK OWNERSHIP, AND INSURANCE PLANS

Substantially all full-time employees of the Organization were eligible to participate in a 401(k) savings plan. Under the plan, employees could contribute up to 15% of their pay on a tax-deferred basis. The Organization matched the deferred amount up to 5% of each employee's annual compensation. The Organization's contributions become 10% vested after one year, 25% after two years, 50% after three years, 75% after four years, and 100% after five years.

The Organization offered its employees a variety of medical and dental options. The Organization shared in the cost of the coverage. The Organization also provided workers compensation insurance, long-term disability insurance, and basic group-term life insurance at no

cost to employees. Optional benefits included supplemental life insurance and short-term disability insurance.

Under the terms of an Employment Termination and Consulting Agreement, Val H. Christensen resigned as Chief Executive Officer of the Organization, terminated his Employment Agreement and Executive Stock Agreement, and entered into a consulting relationship with the Organization. The Organization agreed to pay Mr. Christensen $5,850 monthly for three years and to provide at the Organization's cost, health, dental, and vision insurance coverage for Mr. Christensen and his dependents for a period of three years. Mr. Christensen agreed to provide a minimum of one hour of consulting service per week. No provision was made by the Organization for its obligations under the agreement. Provision for the Organization's obligations as of December 31, 2001, are included in the financial statement contained in this report.

Employee benefits did not extend to Organization employees that were transferred to The TriZetto Group, Inc. under a service agreement. (Refer to **HISTORY** – Management)

STATUTORY DEPOSITS

Pursuant to U.C.A. § 31A-8-211(1), the Organization was required to maintain a statutory deposit of $1,762,281. Wells Fargo Bank held U.S. Treasury Notes with a par value of $2,100,000 and a statement value of $2,175,016 under a tri-party agreement with the Department.

INSURANCE PRODUCTS AND RELATED PRACTICES

Policy Forms and Underwriting

The following group and individual products were available with various deductibles and co-payments.

- A traditional HMO product which required the enrollee to select a Primary Care Provider ("PCP"). PCP referrals were required for specialist care.
- A product with two levels of benefits, a full network HMO of participating providers and an indemnity swing option that allowed the enrollee to use non-participating providers. The enrollee was required to select a PCP, but had the option to use any licensed provider.
- A product that required enrollees to seek care from participating providers but permitted open access to any network participating provider.
- An open access, no gatekeeper, product that allowed the enrollee to access health care from participating and non-participating providers.
- A product with the deductible collected up front with a percentage of the health care costs paid by the Organization. The enrollee was responsible for the difference.
- A product for individuals and families without group coverage options that had access to network providers. Enrollees selected from two benefit designs, which were open access, no gatekeeper plans.

Underwriting guidelines for small groups (2-50 enrollees) required a statement of health on all eligible employees applying for coverage, including new hires, mid-year and open enrollment. Statements of health for large groups (50+ enrollees) were only required when medical conditions were identified in the risk evaluation section of the group application. Large groups (100+ enrollees) were required to submit claims experience and a large claims summary. Underwriting could require supplemental medical questionnaires or other medical information on certain medical conditions.

In general, the Organization's risk retention limits per enrollee were $500,000 plus 20% of all services between $500,000 and $1,750,000 plus amounts in excess of $1,750,000 up to the policy limits. Some polices were issued with unlimited policy limits, which exposed the Organization to unlimited risk. (Refer to **REINSURANCE)**

Territory and Plan of Operation

The Organization is an authorized health maintenance organization in the State of Utah. The Organization furnished health care services through arrangements with providers to enrollees in return for prepaid periodic payments. The Organization was obligated to arrange for available and accessible health care. The following counties were included in the Organization's service area.

Box Elder	Morgan	Uintah
Cache	Salt Lake	Utah
Carbon	Sanpete (partial)	Wasatch
Davis	Summit	Washington
Juab (partial)	Tooele	Weber

The Organization marketed its products through employees, independent agents, and insurance agencies. The Organization maintained a sales department, including about 13 sales agents, and contracted with approximately 320 independent sales agents and 200 agencies. Agents and agencies were required to enter into a Producer Agreement. Producers agreed to perform as set forth in the agreement and as set forth in the Organization's administrative guidelines, bulletins, directives, and manuals.

The Organization maintained two provider networks, Premier and Exclusive. Premier contracted with approximately 2800 providers and Exclusive contracted with about 1700 providers. The Organization used the following types of standard fee-for-service provider contracts, which were subject to change by separate amendment:

- physician;
- physician – hospital based;
- midlevel – physician extenders or allied health care;
- vendor – supplies and equipment;
- ancillary Professional – service;
- ancillary Facility – service or procedure; and
- hospital.

Advertising and Sales Material

The Organization's advertising strategy was to get maximum name recognition at the least cost. Advertising with regard to specific insurance policies was not done during the examination period. The Organization participated in the following types of advertising and sales materials:

- magazine and trade publications;
- name listing in various directories for informational purposes only with no advertising;
- television spots;
- internet banner ads;
- internet links from employer sponsored websites to the Organization's website;
- community activities, such as, presence in pre-show publications and/or use of company logo in show-related activities; and
- sales presentation slides.

Treatment of Policyholders

The Organization maintained control over policyholder complaints throughout the examination period. Written procedures to handle written complaints were in place. The Organization maintained a grievance and appeal policy that permitted enrollees the opportunity to request a review of a perceived wrong. The policy allowed enrollees to appeal their cases to a variety of bodies up to and including the Department. The levels of appeal included the following:

- initial review and research by the Appeals and Grievance Department and/or subcommittee;
- review by an Appeals and Grievance Committee;
- review by the Executive Appeals Committee;
- review by the Organization's president; and
- submitting an appeal to the Department.

A review of paid claims did not indicate a problem with regard to the treatment of policyholders. The following chart identifies the number of formal written complaints submitted to the Organization and the Department by or on behalf of enrollees regarding payment, non-payment, or denial of services that the enrollee believed should have been covered.

Period	Total Claims Paid	Organization Claim Appeals	Department Problem Reports	(1) Number of Enrollees	Claim Appeals per Enrollee	Department Reports per Enrollee
1999	(2)	1309	21	87,402	1.4977%	0.0240%
2000	678,843	662	16	92,111	0.7187%	0.0174%
2001	846,429	821	16	95,578	0.8590%	0.0167%

(1) Number of enrollees is equal to member months divided by 12
(2) Unavailable

REINSURANCE

As of December 31, 2001, the Organization maintained an HMO Excess Risk Reinsurance Agreement with American National Insurance Company, which covered plan members enrolled under its commercial HMO and commercial POS Membership Service Agreements. The agreement provided the Organization partial coverage for eligible charges in excess of $500,000 per person, per agreement year, not to exceed $1,000,000 per person, per agreement year. Eligible charges were reinsured as follows:

- 80% of transplants and transplant related eligible services performed at the University of Utah or performed in a URN (Utilization Review Nurse) contracted facility;
- 50% of all other transplants and transplant related eligible services; and
- 80% of all other eligible services.

Eligible services were defined as hospital inpatient facility services, rehabilitation facility services, skilled nursing facility services, and home health care services. Hospital inpatient services specifically excluded any service by a physician or surgeon for which an identifiable separate charge was made. Rehabilitation facility, skilled nursing facility and home health care services coverage was limited to a combined annual contract maximum of sixty days and to the amount that a hospital would charge for such services if the services were rendered by the hospital. Rehabilitation facility, skilled nursing facility and home care services were required to begin within twenty-four hours of a hospital inpatient stay and were also required to be directly related to such stay.

The policy explicitly excluded hospital outpatient services and physician services. In addition, prescription drugs, injectables, and pharmaceuticals not associated with hospital inpatient services or covered rehabilitation facility services, skilled nursing facility services, and home health care services were excluded from coverage.

U.C.A. § 31A-20-108 does not permit the Organization to expose itself to loss on any single risk in an amount exceeding 10% of its capital and surplus. The Organization exposed itself to substantially greater risk than permitted by this section. Policy lifetime benefit maximums range from $2,000,000 to unlimited. Since the maximum reinsurance coverage per individual was $1,000,000, the Organization retained a minimum single risk of $1,000,000. The maximum retained single risk allowed based on year 2001 annual statement capital and surplus was $383,311. Because the reinsurance coverage excluded some benefits included in the Organization's policies and the policy maximum coverage may be greater than $2,000,000, the maximum retained single risk was greater than $1,000,000.

ACCOUNTS AND RECORDS

The Organization's accounting system consisted of a general ledger, journals, registers, and statistical records normally maintained by an HMO. The accounting system utilized a centralized computer record processing system, supplemented by ancillary records maintained manually or on personal computers. An examination trial balance, as of December 31, 2001, was

prepared from an electronic copy of the Organization's computerized general ledger. Account balances were traced to annual statement exhibits and schedules without exception. Individual account balances for the examination period were examined as deemed necessary.

Accounts and records deficiencies included the following:

- Securities custodial agreements were not authorized by a resolution of the Board of Directors or by an authorized board committee as required by U.A.C. R590-178-4.

- As of the examination date, some of the Organization's securities were not held in accordance with U.C.A. § 31A-4-108 and U.A.C. § R590-178-4. Prior to completion of this examination, the Organization's securities were properly held.

- Several bond acquisitions were reported as of the settlement date. NAIC Accounting Practices and Procedures Manual SSAP No.26 requires bond acquisitions to be reported as of the trade date.

- NAIC Annual Statement Instructions for Schedule D – Part 1, Column 5, requires the insertion of the initial letters of months in which interest is payable. The Organization incorrectly inserted the same letters for all semiannual interest payments.

- Authorized bank checking account signatories on two accounts included the Organization's former Chief Executive Officer. Prior to completion of this examination the authorization was removed.

- Credit balances resulting from premium adjustments were improperly reported as premiums received in advance. NAIC Accounting Practices and Procedures Manual SSAP No. 54 defines advance premiums as those premiums that have been received by the reporting entity prior to or on the valuation date but which are due after the valuation date. Premium adjustments do not fall under this definition.

- The net amount of estimated retrospective premium adjustments for retrospectively rated contracts was improperly reported as general expenses due or accrued. NAIC Accounting Practices and Procedures Manual SSAP No. 66 requires that additional retrospective premiums be reported as a write-in for other than invested assets. Annual statement instructions require return retrospective premiums to be reported on Underwriting and Investment Exhibit, Part 2D, Line 4.

As a result of its review of claims unpaid and unpaid claim adjustment expenses, Milliman USA Consultants and Actuaries recommended that the Organization:

- Adopt a policy to follow the concept of conservatism in establishing statutory unpaid claim liabilities. This would entail evaluating the level of variability and uncertainty in the Organization's unpaid claim estimates, determining appropriate conservatism levels based on that variability and adopting steps in the reserve methodology to include an appropriate margin for adverse deviation in future claim liability estimates.

- Carefully review the allocation of expenses and estimate of claim adjustment expenses and use that information to establish an appropriate liability for unpaid claim adjustment expenses.

FINANCIAL STATEMENT

The Organization's financial condition as of December 31, 2001, and the results of its operations during the twelve months then ended, as determined by examination, are reported in the following financial statements:

Balance Sheet as of December 31, 2001;
Statement of Revenue and Expenses – January 1, 2001 through December 31, 2001; and
Capital and Surplus – January 1, 1998 through December 31, 2001.

The accompanying comments on financial statements are an integral part of these statements.

Altius Health Plans Inc.
Balance Sheet
As of December 31, 2001

ADMITTED ASSETS

	Amount	Notes
Bonds	$ 6,815,502	
Common stocks	0	(1)
Cash and short-term investments	7,428,956	
Accident and health premiums due and unpaid	7,021,405	
Health care receivables	1,066,233	
Investment income due and accrued	111,765	
Electronic data processing equipment and software	746,328	(2)
Aggregate write-ins for other than invested assets:		
Prepaid expenses	84,534	(3)
Standby letter of credit	1,000,000	
Deferred tax	207,001	
Total assets	$ 24,481,724	

LIABILITIES

Claims unpaid	$ 17,460,394	
Unpaid claims adjustment expenses	388,609	
Premiums received in advance	313,320	
General expenses due or accrued	2,385,931	(4)
Amounts due to parent, subsidiaries and affiliates	248,710	(5)
Aggregate write-ins for other liabilities:		
Escheat liability	50,177	
Lease payable	73,432	
Total liabilities	20,920,573	
Common capital stock	218,000	
Preferred capital stock	3,400,000	
Gross paid in and contributed surplus	9,947,946	
Surplus notes	11,156,731	
Equity impact of standby letter of credit	1,000,000	
Unrealized loss on investment in a subsidiary	0	(1)
Unassigned funds (surplus)	(22,161,526)	
Total capital and surplus	3,561,151	
Total liabilities, capital stock and surplus	$ 24,481,724	

Altius Health Plans Inc.
Statement of Revenue and Expenses
January 1, 2001 through December 31, 2001

	Amount
Net premium income	$166,228,096
Administrative fees	215,388
Total revenue	166,443,484
Hospital/medical benefits	86,104,841
Other professional services	60,233,770
Subtotal	146,338,611
Net reinsurance recoveries	35,782
Total medical and hospital	146,302,829
Claims adjustment expenses	1,405,810
General administrative expenses	20,703,959
Total underwriting deductions	168,412,598
Net underwriting gain or (loss)	(1,969,114)
Net investment income earned	373,933
Gain on sale of service center assets	5,880,884
Net income or loss before federal income taxes	4,285,703
Federal income taxes	207,002
Net income	$ 4,492,705

Altius Health Plans Inc.
Capital and Surplus
January 1, 1998 through December 31, 2001

	1998	1999	2000	Per Exam 2001
Capital and surplus December 31, previous year	$ (3,997,318)	$ 5,045,381	$ 420,479	$ (5,409,925)
Net income (loss)	(24,342,816)	(12,080,477)	(7,344,969)	4,492,705
Net unrealized capital gains and losses				(1,000)
Change in non-admitted assets and related items	20,001,450	(745,561)	364,195	(239,795)
Change in surplus notes	(51,574,238)	8,093,488	1,579,421	1,271,821
Capital paid-in	(12,879,234)	100,601		2,447,345
Close out retained earnings due to PacifiCare acquisition	77,837,537			
Prior period adjustment		7,047		
Settlement with PacifiCare related to acquisition			(429,051)	
Equity impact of standby letter of credit				1,000,000
Net change in capital and surplus for the year	9,042,699	(4,624,902)	(5,830,404)	8,971,076
Capital and surplus, December 31, current year	$ 5,045,381	$ 420,479	$ (5,409,925)	$ 3,561,151

COMMENTS ON FINANCIAL STATEMENT

(1) Common stocks **$ 0**

The equity value of the Organization's wholly owned subsidiary, Altius Health Administrators Inc., was reported as ($73,419). NAIC Accounting Practices and Procedures Manual SSAP No. 46 requires insurers to discontinue applying an equity method when the investment is reduced to zero. Insurers are not permitted to provide for additional losses unless the insurer has guaranteed obligations of the subsidiary or is otherwise committed to provide further financial support for the subsidiary.

(2) Electronic data processing equipment and software **$ 746,328**

The reported amount, $783,135 was reduced by $36,807. Nonoperating system software, not specifically permitted by the Department to be reported as admitted assets, was nonadmitted in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 16.

(3) Prepaid expenses **$ 84,534**

The reported amount, $118,571 was reduced by $34,037. Prepaid expenses, not specifically permitted by the Department to be reported as admitted assets, were nonadmitted in accordance with NAIC Accounting Practices and Procedures Manual SSAP No. 29.

(4) General expenses due or accrued **$ 2,385,931**

The reported amount, $2,185,815 was increased by $200,116. The increase represents unreported post-employment benefits granted to a former chief executive officer. NAIC Accounting Practices and Procedures Manual SSAP No. 11 establishes statutory accounting principles for post-employment benefits. An insurer is required to recognize a liability for contractual termination benefits when it is probable that employees will be entitled to benefits and the amount can be reasonable estimated.

(5) Amounts due to parent, subsidiaries and affiliates **$ 248,710**

The reported amount, $174,291 was increased by $74,419 to recognize the actual amount due to the Organization's wholly owned subsidiary, Altius Health Administrators Inc.

CAPITAL AND SURPLUS

The Organization's capital and surplus was determined to be $271,960 less than reported. The following schedule identifies examination changes:

Description	Annual Statement Dr (Cr)	Examination	Change in Surplus Inc (Dec)	Notes
Common stocks	$ (73,419)	$ 0	$ 73,419	(1)
Electronic data processing equipment and software	783,135	746,328	(36,807)	(2)
Prepaid expenses	118,571	84,534	(34,037)	(3)
General expenses due or accrued	2,185,815	2,385,931	(200,116)	(4)
Amounts due to parent, subsidiaries and affiliates	174,291	248,710	(74,419)	(5)
Total changes			(271,960)	
Capital and surplus per Organization			3,833,111	
Capital and surplus per examination			$3,561,151	

U.C.A. § 31A-8-209(1) required the Organization to maintain minimum capital in the amount of $100,000. U.C.A. § 31A-8-209(4) required the Organization to maintain minimum assets in an amount equal to the total of the Organization's liabilities, minimum capital, and the company action level RBC as defined in U.C.A. § 31A-17-601(8)(b). By letter dated, May 30, 2001, the Department permitted the Organization to phase-in RBC requirements. The RBC phase-in timeline as modified by the Department's letter dated August 31, 2001, follows:

Year End	Annual %	Cumulative %
2001	5	5
2002	10	15
2003	15	30
2004	30	60
2005	40	100

The Organization did not have sufficient assets to meet the phased-in capitalization requirements as of December 31, 2001, as shown below:

Admitted Assets	$24,481,724
Liabilities	20,920,573
Minimum Capital	100,000
Compulsory Surplus	3,324,562
5% RBC Phase-in Requirement	335,719
Total	24,680,854
Additional Assets Required	$ 199,130

SUMMARY

Items of significance or special interest contained in this report are summarized below:

(1) Effective September 30, 1998, Elan Health Partners LLC ("Elan"), a Utah limited liability company, acquired all of the issued and outstanding stock of the Organization. **(HISTORY – General)**

(2) On September 20, 2001, Croghan & Sipf Healthcare Enterprises, LLC ("Croghan & Sipf"), a Delaware limited liability company, purchased 50,000 shares of common stock and 2,400,000 shares of preferred stock from the Organization. **(HISTORY – General)**

(3) U.C.A. § 31A-5-305(1)(a)(iii) requires common stock to have a stated par value. The Organization was not in compliance with this requirement. **(HISTORY – Capital Stock)**

(4) Croghan & Sipf and Elan each owned 50,000 shares of common stock of the Organization and were the immediate controlling persons. Each entity was more than 10 percent owned by other persons. **(HISTORY – Capital Stock)**

(5) Pursuant to a Shareholders Agreement the size of the Organization's board was set at nine. Croghan & Sipf, was given the right to designate five board members, Elan was given the right to designate two board members, and SunAmerica, Inc. was given the right to designate two board members. **(HISTORY – Management)**

(6) Employment Agreements were entered into with officers. **(HISTORY – Management)**

(7) Although the board did not adopt a resolution designating committees, the board appointed members to board committees. **(HISTORY – Management)**

(8) Effective June 15, 2001, the Organization entered into a seven-year Services Agreement with The TriZetto Group, Inc. **(HISTORY – Management)**

(9) The Organization did not have an established procedure to report conflicts of interest to the board of directors. **(HISTORY – Conflict of Interest Procedure)**

(10) No annual shareholder meetings were held during the examination period. **(HISTORY – Corporate Records)**

(11) The Organization did not maintain a complete record of its Board of Directors and its board committee meetings nor was the purchase or sale of all investments passed upon by the board or a subcommittee as stated in its 2001 annual statement general interrogatories. **(HISTORY – Corporate Records)**

(12) In general, a review of board of director minutes indicated that the board did not adequately approve and support the Organization's transactions and events. **(HISTORY – Corporate Records)**

(13) In 1999 the Organization formed a wholly owned subsidiary, Altius Health Administrators Inc. **(HISTORY** – Acquisitions, Mergers, Disposals, Dissolutions, and Purchases or Sales through Reinsurance)

(14) All existing surplus notes were restructured on September 20, 2001. **(HISTORY** – Surplus Debentures)

(15) The Organization is a member of an insurance holding company system. **(AFFILIATED COMPANIES)**

(16) The Organization did not notify the Commissioner in writing of its intention to enter into a management agreement with an affiliate at least 30 days prior to entering into the transaction as required by U.C.A. § 31A-16-106(1)(b)(iv). **(AFFILIATED COMPANIES)**

(17) The amount of fidelity insurance coverage recommended by the National Association of Insurance Commissioners for an insurer of the Organization's size was between $800,000 and $900,000. The Organization had fidelity coverage with a single loss limit of $500,000. **(FIDELITY BOND AND OTHER INSURANCE)**

(18) Under the terms of an Employment Termination and Consulting Agreement, Val H. Christensen resigned as Chief Executive Officer of the Organization, terminated his Employment Agreement and Executive Stock Agreement, and entered into a consulting relationship with the Organization. **(PENSION, STOCK OWNERSHIP, AND INSURANCE PLANS)**

(19) U.C.A. § 31A-20-108 does not permit the Organization to expose itself to loss on any single risk in an amount exceeding 10% of its capital and surplus. The Organization exposed itself to substantially greater risk than permitted by this section. **(REINSURANCE)**

(20) Several accounts and records deficiencies or concerns were identified. **(ACCOUNTS AND RECORDS)**

(21) The consulting actuarial firm made two recommendations. **(ACCOUNTS AND RECORDS)**

(22) The Organization did not have sufficient assets to meet the phased-in capitalization requirements as of December 31, 2001. **(CAPITAL AND SURPLUS)**

CONCLUSION

Assistance and cooperation extended during the course of the examination by officers, employees, and representatives of the Organization are acknowledged. In addition to the undersigned, Donald R. Catmull, Financial Examiner, participated in the examination. John Kay, CFE, CIE, Assistant Chief Examiner supervised the examination. Lorraine Mayne, FSA, MAAA, Consulting Actuary with Milliman USA conducted the actuarial phases of the examination.

Respectfully submitted,

C. Kay Anderson, CFE
Examiner-in-Charge, representing the
Utah Insurance Department